Human Resources/Employee Benefits & Services
TERMINATING FULL-TIME EMPLOYEES
Payroll/Personnel Assistant (PPA) Check List & Instructions

Name: _____ SSN: _____

Dept/Div: _____ Position: _____

Certificate of Group Health Plan Coverage (HIPAA) Form

Complete all areas and distribute as follows: original form to dependent; place one copy in the employee's department personnel file.

1. Date you are completing form.
2. Current health and dental plan.
3. Employee's name should go in the space for participant name.
4. Employee's Social Security Number.
5. Names of any dependents on employee's health/dental plans.
6. City of Long Beach is always the Plan Administrator, your department's name and address.
7. Put your name and phone number as the contact.
8. If the employee has been covered with no break in coverage for a period of 18 months or longer, check the box on number 8 and skip numbers 9 and 10.
9. If the employee has not been covered or has a break in coverage during the last 18 months, complete numbers 9 and 10.
10. Line 12 should be completed as appropriate.

COBRA Continuation of Health Coverage

Mail a copy of the COBRA letter (City Employees and Families) to the employee being deleted. After mailing the letter, prepare a Proof of COBRA Notification Form and place it in the employee's department personnel file.

COBRA Election Form

If the dependent elects to enroll in COBRA, you must complete all areas of the COBRA Election Form and forward it to the employee.

1. Complete the name, address, social security number and phone number of the employee on the top lines.
2. List the existing health/dental plans, type of qualifying event, and date of qualifying event.
3. Under the Effective Date COBRA Coverage Begins, this date is always the first day of the month following the qualifying event.
4. Check box for continue coverage for employee.
5. Enter the date coverage ends, which must be 18 months from the date that COBRA begins (unless disabled).
6. Enter the monthly amounts (from the yearly COBRA rate charts you are given) and ensure that you have indicated the health/dental plans.

7. Sign and date the bottom of the form.
8. Forward this form to the employee, along with instructions that they need to indicate if they wish to continue or not with the plans. Also, please indicate that they need to circle with or without dental insurance.
9. When you receive the form back from the employee, forward it to Employee Benefits & Services.